Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF ELDER ABUSE IDENTIFICATION, INVESTIGATION AND RESOLUTION PROCEDURES FOR ILLINOIS LONG-TERM CARE FACILITIES

## ILLINOIS DEPARTMENT ON AGING
## ILLINOIS DEPARTMENT OF PUBLIC HEALTH

**JUNE GIBBS BROWN**
**Inspector General**

**MAY 1998**
**A-05-97-00010**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

REGION V
105 W. ADAMS ST.
CHICAGO. ILLINOIS 606036201

May 27. 1998

OFFICE OF
INSPECTOR GENERAL

CIN: A-05-97-00010

Ms. Maralee I. Lindley. Director
Illinois Department on Aging
421 East Capital Street
Springfield. Illinois 6270 1

Dear Ms. Lindley:

Enclosed are two copies of the U.S. Department of Health and Human Services. Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Elder Abuse Identification. Investigation and Resolution Procedures for Illinois Long-Term Care Facilities" for the audit period July 1. 1994 through December 3 1. 1996. A copy of this report will be forwarded to the action official noted below for his/her review and an?; action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In a written response dated April 3. 1998. the IDPH officials generally agreed with our findings and recommendations, However. they stated that staff and resource considerations would limit the extent they could implement some of our recommendations. Our recommendations and the IDPH's comments to our draft report are included as Attachment C to this report and are summarized after each finding and recommendation in the report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23). OIG. OAS reports issued to the Department's grantees and contractors are made available. if requested. to members of the press and general public to the estent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification. please refer to the Common Identification Number (CIN) A-05-97-000 10 in all correspondence relating to this report.

Sincerely.

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures

**Direct Reply to HHS Action Official:**
Director. Grants Management Division
Wilbur J. Cohen Building. Room 4643
330 Independence Avenue. S. W.
Washington. D. C. 2020 1

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

REGION V
105 W. ADAMS ST.
CHICAGO. ILLINOIS 60603-620 1

May 27. 1998

OFFICE OF
INSPECTOR GENERAL

CIN: A-05-97-00010

Dr. John R. Lumpkin, Director
Illinois Department of Public Health
535 West Jefferson
Springfield. Illinois 6276 1

Dear Dr. Lumpkin:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG). Office of Audit Services' (OAS) report entitled "Review of Elder Abuse Identification, Investigation and Resolution Procedures for Illinois Long-Term Care Facilities" for the audit period July 1, 1994 through December 3 1. 1996. A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

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Washington, D.C. 20201

# EXECUTIVE SUMMARY

## OBJECTIVES

The objectives of our review were to assess the effectiveness of the procedures established to identify, investigate and resolve reports of elder abuse in Illinois long-term care (LTC) facilities and to evaluate the accuracy and completeness of the certified nurse aide (CNA) registry. We also determined whether LTC facilities employed alleged abusers, who had undisclosed criminal backgrounds which would have been identified if the Illinois Health Care Workers Background Check Act (HCWBC Act) had been implemented sooner.

## FINDINGS

The Illinois Department on Aging (IDOA) and the Illinois Department of Public Health (IDPH) share responsibility for the identification. investigation and resolution of elder abuse in LTC facilities, although IDPH has primary responsibility. Our audit determined that some alleged abuses reported by the LTC facilities were not fully developed or investigated by IDPH. While employees in 13 of 88 alleged abuse cases in our sample were terminated from employment or disciplined, the IDPH did not determine whether the alleged abuses actually occurred. Although the actions taken by the LTC facilities and the reports of alleged abuse provide some indications that an abusive situation may have occurred, IDPH did not perform additional on-site investigative procedures or initiate other evidence gathering procedures to substantiate the abuse.

We found that IDPH was adequately maintaining the CNA registry for substantiated cases of abuse and that the registry was available to the LTC facilities to screen candidates during their hiring process. Only one instance of substantiated abuse and one instance of abuse conviction were not recorded on the CNA registry. We attribute these minor omissions to an administrative oversight. We did find. however, that background checks without disqualifying criminal histories were not recorded on the CNA registry in a timely manner. We also found that nursing homes terminated 10 CNAs they suspected committed elder abuse. However, because IDPH did not perform an investigation to substantiate whether an abuse occurred and should be posted to the registry, these individuals were free to seek employment at other LTC facilities or allowed to continue their employment which could place residents at risk. The registry can be a valuable resource by providing accurate and comprehensive information which could be used by the LTC facilities in their hiring process. Therefore, we believe that the positive background check information, as well as terminations for alleged abuse which was substantiated, should be posted to the registry.

Finally, the benefit from implementing the Illinois background check law is evident from the results of our review during the period prior to HCWBC Act enactment. We noted 15 CNAs and two non-CNA employees with disqualifying criminal backgrounds who were working at LTC facilities but would have been identified and likely excluded had the Act been in place and non-CNA employees had been subjected to the Act. All 17 of these employees were later involved in

instances of alleged elder abuse. Fourteen of these 15 CNAs are no longer employed by LTC facilities. Seven of the CNAs were terminated as a result of substantiated findings of abuse, and the other seven were dismissed by the LTC facility or resigned subsequent to the abuse allegation. The remaining CNA was transferred to a non-direct resident care position. The two non-CNA employees were terminated by the facility due to elder abuse.

While the above employees were hired before the effective date of the HCWBC Act, it does demonstrate the positive effects that resulted from the State's initiative in this area. These efforts should mitigate the number of future abuses by not hiring prospective employees who have disqualifying criminal convictions. However, the HCWBC Act limits LTC facilities to the use of Illinois State Police (ISP) criminal conviction data for their background checks. The HCWBC Act does not provide for the use of ISP arrest data nor does it authorize the use of other States' or national data bases. Therefore, we believe the provisions of the HCWBC Act should be expanded to allow use of other data bases and ISP arrest and final disposition information.

## RECOMMENDATIONS

We are recommending that IDPH more fully develop incident reports involving disciplinary action by the facility. We are also recommending that IDPH update the CNA registry to include all instances of substantiated abuse or abuse convictions and timely posting of background checks without disqualifying crimes. In addition, we are recommending that the provisions of the Illinois Nursing Home Care Act (INHC Act) be expanded to require registry posting of CNA terminations made by LTC facilities based on alleged abuse which was substantiated. Finally, we are recommending that the HCWBC Act be expanded to allow the LTC facilities to use additional criminal data bases, expand the scope of the background checks to include all LTC staff, not just direct care staff, and use ISP arrest data along with final disposition information.

*****

In a written response dated April 3, 1998, the IDPH officials generally agreed with our findings and recommendations. However, they stated that staff and resource considerations would limit the extent they could implement some of our recommendations. Our recommendations and the IDPH's comments to our draft report are included as Attachment C to this report and are summarized after each finding and recommendation in the report.

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# INTRODUCTION

## BACKGROUND

Under the Older Americans Act, the States are allotted funds to establish long-term care ombudsman programs and to develop programs for the prevention of elder abuse, neglect and exploitation. Specifically, the States were required to establish mechanisms to identify, investigate and resolve complaints of alleged abuse involving the elderly in LTC facilities. The IDPH and the IDOA are both responsible for the identification, investigation and resolution of alleged elder abuse. The IDPH has the primary responsibility for the investigation and resolution of alleged abuse cases which are received from various sources. The IDOA is responsible for administering the Long-Term Care Ombudsman program and coordinating the efforts of its limited number of employees and local volunteers to identify elder abuse in local LTC facilities.

Under the Illinois statute, entitled "The Abused and Neglected Long Term Care Facility Residents Reporting Act" (Act), the IDPH:

> *...shall upon receiving reports made under this Act, seek to protect residents and prevent further harm to the resident who was the subject of the report....*

The Act requires that LTC facility administrators, any physician, hospital, social worker, and field personnel of the IDPH and Illinois Department of Public Aid must report suspected abuse to the IDPH. In addition any person who has reasonable cause to suspect abuse or neglect may report it to IDPH. The IDPH is required to initiate an investigation of all reports of alleged elder abuse, oral or written, and to keep a continuing record of all reports, including the final determination of the investigation and the final disposition of all reports of alleged abuse. IDPH must refer severe cases of abuse, as well as, complaints and potential criminal conduct to the ISP.

The IDOA's ombudsman program, receives reports of alleged abuse from several sources including the facility, residents, family members, and other concerned individuals. Under State law, ombudsmen are required to report a complaint or an investigation showing suspected abuse or neglect of a facility resident to IDPH for further development and investigation.

The IDPH categorizes reports of alleged abuse as complaints or incident reports. Complaints are received from concerned parties, including the ombudsman program, either in writing or through telephone calls to the toll-free hotline, and are recorded in the central complaint registry. Investigations are performed to determine if abuse occurred. The IDPH receives incident reports from LTC facilities that provide the written perspective of their internal investigations of alleged abuse. These reports are manually recorded on the incident report log.

During the course of resolving reports of abuse, IDPH determines whether the allegations are warranted. For the incident reports received from the LTC facility, IDPH either relies upon the facility's written reports, requests additional information, or conducts its own investigation. If

IDPH determines that CNA abuse, neglect, or misappropriation of property occurred, they must notify the employee, the facility and the nurse aide registry. The aide is given an opportunity to contest the finding in a hearing before an administrative law judge or to submit a written response in lieu of the hearing. After the hearing or when findings are not contested, the IDPH will enter the substantiated findings on the nurse aide registry. Although the IDPH can, after netifying the aide, remove the aide from the registry, as a practical matter it is not usually done. Rather, the annotation, in effect, invalidates the CNA's certification. Since the INHC Act requires that IDPH maintain a CNA registry with substantiated findings of abuse and precludes LTC facilities from employing CNAs without first checking the registry, removal from the registry adversely affects their employability. The registry provides a ready reference to an applicant's certification, and disqualifying substantiated abuse or criminal convictions. Allegations of abuse involving licensed physicians and licensed registered and practical nurses are maintained separately and are handled by the Illinois Department of Professional Regulation (DPR).

In July 1995, the Illinois State Legislature passed the HCWBC Act, which required that all non-licensed persons seeking employment in direct care position in LTC facilities after January 1, 1996, have a criminal background check. The Act did not include those licensed under the DPR, i.e., doctors, nurses, chiropractors and those licensed by IDPH such as emergency medical technicians. The Act provides that individuals, expected to have direct contact with facility residents, may not be hired if they have certain criminal convictions. Convictions that would disqualify a person from working in a LTC facility include murder, theft, sexual assault and criminal neglect of an elderly or disabled resident. By January 1, 1997, all current employees in direct care positions, except those licensed by either DPR or IDPH must have a criminal background check initiated on their behalf by the employing facility. In Illinois, checks are conducted against the ISP records which contain only in-state convictions. The results of the background checks, whether positive or negative, must be recorded on the CNA registry. Should the CNA seek employment elsewhere, the background checks are valid for one year. Thereafter, a new background check is required.

## SCOPE OF AUDIT

Our review was conducted in accordance with generally accepted government auditing standards. The objectives of this review were to: (I) assess the effectiveness of the procedures established to receive, coordinate, investigate and resolve reports of elder abuse in Illinois LTC facilities, (ii) evaluate the accuracy and completeness of the CNA registry to include substantiated findings of abuse and results of background checks, and (iii) determine whether alleged abusers with undisclosed criminal backgrounds were employed in LTC facilities prior to the Illinois HCWBC Act being implemented.

To accomplish our objectives, we reviewed applicable Federal and State laws and regulations and the IDPH and IDOA policies and procedures related to elder abuse. We also reviewed

Federal and State requirements for criminal background checks related to employees of LTC facilities for the elderly. We did not evaluate elder abuse allegations resolved by the DPR.

We identified a universe totaling 1,980 abuse reports during the period July 1, 1994 through June 30, 1996. These abuse reports originated from a variety of sources including the resident, relatives, phone calls or letters by concerned individuals, and the LTC facilities. Our universe included cases involving developmentally disabled persons which were not related to elder abuse. We were unable to segregate and exclude these cases from our universe. The established universe consisted of 7 15 IDPH complaints, 1,102 IDPH incident reports, and 163 IDOA cases not referred to IDPH. The non-referred category included cases previously reported to IDPH by the LTC facility, resident-on-resident abuse situations, and withdrawn cases.

We selected a random sample of 160 of the 1,980 abuse reports. Our sample included 86 incident reports, 64 complaints, and 10 IDOA non-referrals. Of the 160 abuse reports, 36 were developmentally disabled cases, which were not included in the scope of the audit. For the remaining 124 abuse reports, we examined data developed by IDOA or IDPH to resolve the cases. We also determined whether the CNA registry was accurate and complete, in that it contained substantiated abuse findings, convictions of abuse, and background check results.

Out of the 124 abuse reports, 36 related to resident-on-resident abuse and not employee abuse of residents. These reports were excluded from our scope of review. For the remaining 88 abuse reports, we established whether the person involved in the abuse was employed by a LTC facility and had an undisclosed criminal history. We reviewed comprehensive profiles of criminal background maintained in the Federal Bureau of Investigation's (FBI) National Crime Information Center (NCIC) system and the ISP criminal data base for each of the alleged abusers. For background checks that did not contain disposition information concerning criminal arrests, we obtained disposition information from county clerk of circuit court offices to determine whether the arrest resulted in conviction or acquittal.

The audit covered the period July l, 1994 through December 3 1, 1996. The field work was performed between January 1997 through November 1997 at the IDPH and IDOA central offices in Springfield and at the Cook County Clerk of Circuit Court Office in Chicago.

## RESULTS OF AUDIT

Our audit showed that the State's procedures used to investigate and resolve instances of elder abuse were generally effective. The IDOA Long-Term Care Ombudsman program performed its role by ensuring that complaints of elder abuse were directed to IDPH for resolution. The IDPH adequately resolved most of the reported cases of alleged elder abuse and generally maintained

an accurate and complete CNA registry. We also found that IDOA and IDPH generally met the requirements of the laws of the State of Illinois and the Federal regulations.

We did find, however, that 13 of 88 incident reports of elder abuse by CNAs, who were disciplined or terminated from employment by the facilities, were not fully developed and resolved independently by IDPH. Since terminations based on alleged abuse were not substantiated, the registry was not updated for a complete employer reference. Although background checks with disqualifying convictions were entered on the registry in a timely manner, those background checks that had no disqualifying convictions were entered as time permitted. We also found that the background checks, as specified by present State law, included only CNAs and employees in direct care positions, excluded those persons licensed under DPR and IDPH, and were limited to conviction information in the ISP records.

We are recommending that IDPH more fully develop incident reports involving disciplinary action by the facility. We are also recommending that IDPH update the CNA registry to include all instances of substantiated abuse or abuse convictions and timely posting of positive findings from background checks. In addition, we are recommending that the provisions of the INHC Act be expanded to require a registry posting for CNA terminations made by LTC facilities based on alleged abuse which were substantiated. Finally, we are recommending that the HCWBC Act be expanded to allow the LTC facilities to use additional criminal data bases, expand the scope of the background checks to include all LTC staff, not just direct care staff, and use ISP arrest data along with final disposition information. Details of our review are presented in the following paragraphs.

## ADDITIONAL INVESTIGATION OF REPORTS OF ALLEGED ABUSE

Although IDPH adequately resolved complaints of elder abuse received through direct contacts or hotline referrals, its procedures for investigating and resolving incident reports, received from LTC facilities, could be more effective in protecting residents from abuse if these cases were fully developed and resolved. We found 13 out of 88 cases alleging physical or sexual abuse that should have been-further investigated by IDPH. (See Appendix A.) These incident reports were internally investigated by the facilities and then forwarded to the IDPH for review. In its review of these reports, the IDPH determined that either the actions taken by the facilities were adequate or the investigations by the facilities did not reveal sufficient evidence to proceed with a formal complaint against the alleged perpetrator. In other words, even though these reports alleged physical or sexual abuse and resulted in employee terminations or disciplinary actions by the facilities, IDPH relied primarily on the reports prepared by the facilities without doing an on-site investigation or initiating other evidence gathering procedures to determine whether the allegations were significant enough to refer for criminal enforcement or entry on the abuse registry. Consequently, these 13 CNAs can still be employed by LTC facilities, potentially placing residents at the risk of abuse.

The provisions of 42 CFR 488.335 (a) (2), which are incorporated into the IDPH's Surveyors Guide for Complaint Investigation, state:

> *"If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident . . . . the State must investigate the allegation."*

Of the 13 employees named in the abuse reports, 10 were terminated by the facility but were not barred from subsequent employment at another facility. For the three other employees, the facilities used administrative actions; a transfer to another facility, probation, and a formal warning, as disciplinary measures. We believe that these actions taken by the facilities for all 13 employees, along with the allegations in the reports, provide some indications that abuse may have taken place. For example, one report stated that a CNA struck a resident on the face and buttocks. Another report stated that a CNA threw a resident onto the bed. Although the two CNAs involved in these incidents were terminated, further development was not initiated by IDPH to establish that actual abuse had occurred or did not occur. Although the IDPH did not accept the facility's referral and termination or disciplinary actions as sufficient bases for inclusion on the CNA registry, it did not have sufficient basis for closing the case and excluding information from the CNA registry.

Since the terminated or disciplined employees were not charged with substantiated abuse and entered on the CNA registry, they remain employable at other LTC facilities. The other facility would not have knowledge of a past history of alleged abuse for these employees. In our opinion, these incident reports should have been more thoroughly investigated by IDPH. If not provided by the facility, further development could include information such as written statements from witnesses, the resident's medical and social records, telephone interviews and follow up with law enforcement officials. This information would provide additional support to either proceed with more investigative work or close the case. On-site investigations should also be considered when the results of additional development disclose inconsistencies between the facility's report and the evidence gathered.

## Recommendation

We recommend that IDPH more fully develop incidents of alleged abuse where the facilities have taken disciplinary actions or terminated CNAs and post to the registry all substantiated cases.

**IDPH Comments:** The IDPH officials agreed that facility disciplinary action is one factor to consider in evaluating a case, but they didn't believe that it should be the only factor to consider in whether cases should be more fully developed. They stated that they have closed some cases in which the facilities took disciplinary action and, on the other hand, taken action against CNAs when disciplinary action was not taken by the facility. They also stated that, because of their

limited staff, they must exercise some judgment as to which on-site investigations are likely to result in actions taken against a CNA.

The IDPH officials agreed that improvements could be made to the handling of incident reports. One of the improvements which has been made is to refer all reports of employee termination for abuse to the ISP for an independent investigation. In addition, they are evaluating other processes to improve, such as, whether other evidence gathering procedures can be used including conducting more on-site visits.

**OIG Response:** We believe the proposed changes will enhance the investigation and resolution of incident reports. However, we believe that these changes will be effective only if IDPH emphasizes the need for facilities to fully develop incident reports, i.e., reports that are accurate and complete and in sufficient detail so that the complaints can be resolved. While IDPH is proposing to refer all cases of terminations for abuse to the ISP for investigation, we believe that because of its workload ISP may not always have the resources to fully investigate these cases. We are also concerned that the ISP's efforts may be focused more on the criminal aspects instead of on the overall safety and well-being of the residents. Therefore, IDPH needs to continue to fully develop these cases on its own. In addition, IDPH needs to follow up on its referrals to the ISP for its resolution of the cases.

## ACCURACY AND COMPLETENESS OF CNA REGISTRY

Although the IDPH was adequately maintaining the CNA registry, some improvements could be initiated to increase the usefulness of this registry for employment screening purposes. We noted only one substantiated case of physical abuse and one abuse conviction that were not recorded on the registry. The IDPH officials confirmed that the omissions were inadvertent oversights. In addition, registry enhancements, such as more timely posting of positive background checks, i.e., no confirmed disqualifying criminal history, would improve the quality of the CNA registry as an employer reference tool. The addition of terminations for substantiated alleged abuses, discussed in the previous section, would also improve the usefulness of the registry. The registry can be a valuable resource-by providing accurate and comprehensive information which could be used by the LTC facilities in their hiring process. However, to serve this purpose, we believe that, at a minimum, the results of all background checks, including positive results, must be posted timely and an indicator of prior termination of an employee for alleged abuse should be added to the CNA registry, if substantiated. The IDPH officials stated that the INHC Act would need to be amended to provide these enhancements to the registry.

The IDPH posted background checks with disqualifying convictions to the registry but delayed posting background checks which did not have disqualifying convictions until time permitted. Some of these background checks were not posted for up to nine months after the check was completed. The IDPH officials advised that the volume of background checks, generated by compliance with the HCWBC Act, prevented the timely posting of positive background checks to the CNA registry. We commend the IDPH for its initiatives and effort, even with limited staff,

needed to accomplish this task in light of the volume of postings generated by the Act. However, for the registry to be valuable as an employer reference source, background check results need to be posted timely. State of Illinois 225 Compiled Statutes 46, Section 30 (b) states:

> *The Department of Public Health shall notify each health care employer inquiring as to the information on the State nurse aide registry of the date of the nurse aide's last UCIA criminal history record check. If it has been more than one year since the records check, the health care employer must initiate or have initiated on his or her behalf a UCIA criminal history record check for the nurse aide pursuant to this Section. The health care employer must send a copy of the results of the record check to the State nurse aide registry for an individual employed as a nurse aide.*

The timely posting of background results would not only be valuable in the hiring process for the LTC facilities but would also provide a record that the required background check had been completed. In addition, timely postings would provide a savings to the LTC facility in that the costs of performing duplicative background checks could be avoided. Therefore, the IDPH should make a concerted effort to post the results of all background checks to the registry in a timely manner.

Posting prior terminations based on alleged abuse, which were subsequently substantiated, would provide potential employers with the opportunity to obtain additional information about applicants' past employment history. In order to protect the rights of the applicants, IDPH should use its hearings process to notify terminated employees that a referral was made and that they have an opportunity to refute the alleged abuse. These persons can provide evidence which they believe could rebut their negative work histories.

The registry requirements, provided in 42 CFR 483.156, establish the minimum information which must be contained in the registry; such as, the individuals name, date individual became eligible for certification, documentation of the State's investigation, date of hearing, if held, etc. These are minimum requirements and the regulations do not prohibit the State from adding additional information to the registry. Therefore, we believe that, for the registry to be effective as an employer reference tool, the IDPH registry should include information related to terminations with substantiated abuse.

## Recommendations

We recommend that IDPH update its CNA registry to include all instances of substantiated abuse or abuse convictions and a timely posting of background checks without disqualifying criminal histories.

We also recommend that the INHC Act be amended so that those terminations, which resulted from alleged abuse and substantiated, can be posted to the registry.

**IDPH Comments:** The IDPH officials agreed and stated that the backlog of background checks has been posted to the registry.

**OIG Response:** We recognize that there was a large volume of background checks generated as a result of the State background check law and commend IDPH for its efforts in becoming current in the posting of these checks to the registry.

**IDPH Comments:** While IDPH officials agreed that a past termination was a factor for a prospective employer to consider in the hiring process, they also stated that past employers would be reluctant to provide this type of information to the registry. They further stated that a facility's decision to terminate an employee because of allegations of abuse is not a reliable indicator that abuse occurred. According to IDPH officials, a number of facilities terminated the alleged abuser regardless of the evidence because the facilities believed they must protect themselves. In other cases, terminations were made in retaliation for such things as union activities, filing a Workmen's Compensation claim or cooperating with IDPH during an investigation.

As an alternative to adding this information to the registry, IDPH believes this issue can be better addressed by mandating that past employers provide this information to prospective employers.

**OIG Response:** We have revised the text of the finding to emphasize that the registry should only be updated for those cases of alleged abuse which were substantiated through the hearing process. In addition, we revised our original recommendation to state that those terminations resulting from alleged abuse **that was substantiated,** should be posted to the registry.

We do not believe that IDPH's alternative solution? i.e., mandating previous employers to provide work history to prospective employers is an acceptable approach. Applicants may not share prior employment references with prospective employers, especially if the applicant has a poor work history. Furthermore, in fear of lawsuits, we believe that previous employers will not share employment history with prospective employers. In those instances where an employee was terminated before developing an abuse case, there may be inadequate documentation for IDPH to reach a decision as to whether or not abuse occurred. Rather than allowing these cases to be dropped with no outcome, use of the hearing process would bring these cases to a conclusion.

## EMPLOYEES WITH UNDISCLOSED CRIMINAL BACKGROUNDS PRIOR TO IMPLEMENTATION OF THE HCWBC ACT

In order to determine whether any of the alleged instances of abuse could have been prevented had the Illinois law been in effect prior to our audit period, we performed background checks on all alleged perpetrators of abuse in our sample. We requested background checks through the ISP and the FBI's NCIC system. The positive benefit of performing background checks is evident

from our results which showed that prior to the Illinois' adoption of their background check law, 15 CNAs and 2 other employees had disqualifying criminal convictions (See Appendix B) and 13 of these alleged abusers could have been barred from employment, if the background check law had been in effect prior to our audit. While these employees were hired before the effective date of the Illinois' Background Check law, it does demonstrate that Illinois' initiative in this area should mitigate the number of future abuses by not hiring prospective employees who have disqualifying criminal convictions.

**Certified Nurse Assistants.** The background checks for 15 CNAs disclosed disqualifying convictions as defined by the State law. The disqualifying convictions ranged in severity from retail theft to aggravated battery to attempted murder. Had IDPH or the LTC facility been aware of these disqualifying criminal convictions, and had the law been in effect, 12 CNAs associated with 88 alleged abuse cases might not have been employed or remained employed after disclosure of the disqualifying conviction. The remaining three instances of alleged abuse could not have been precluded by background checks because the disqualifying convictions occurred concurrent with or subsequent to the alleged abuse incident. Fourteen of the 15 CNAs are no longer employed by LTC facilities. Seven of the CNAs were terminated as a result of substantiated findings of abuse, and the CNA registry was properly annotated for consideration by future employers. The remaining seven were dismissed by the facility or resigned subsequent to the abuse allegation. Should these CNAs seek future employment as direct care providers in LTC facilities, the posting of background check results would provide information to consider during the employment screening process. One CNA, with a 198 1 disqualifying conviction, was still employed in October 1997. The facility had not requested a background check for this individual. However, during the course of our audit, a background check was performed and posted to the registry in December 1997. This individual was transferred to a non-direct care position in January 1998.

**Non-CNA Employees.** Two non-CNA employees not involved in direct care, were accused of elder abuse. One of the employees was terminated by the facility. A background check showed that this employee had a disqualifying aggravated criminal sexual abuse conviction. For the other employee, IDPH substantiated the abuse allegation and sanctioned the facility, and the facility terminated the employee. This employee was convicted of three disqualifying crimes, including aggravated criminal sexual assault.

Because the background check law is limited to direct care employees and excludes employees licensed under DPR and IDPH, neither of these convicted felons would be subjected to a routine background check. As a result, they would not be subjected to possible termination from the current facility or barred from seeking employment at another LTC facility.

We believe that consideration should be given to expanding the provisions of the HCWBC Act to include checks for all LTC employees. We noted that a task force also recommended expanding the background check to additional employees. The Act required that a task force be established to make recommendations for changes to the Act. The task force issued its final report in

December 1997. One of the issues the task force addressed was whether additional employees should have criminal history background checks. The task force's report stated that, the task force:

> *"...supports increasing covered employees by removing the exemption of individuals licensed by Department of Professional Regulation... ".*

The report further stated:

> *"Moreover, there appears to be no basis for allowing health care employers to hire licensed direct care workers with criminal backgrounds when they would be prohibitedji-om hiring unlicenced workers with the same backgrounds."*

The task force recommended that the applicability be expanded to include all individuals who provide direct care and are retained or employed by a health care employer.

**Additional Screening Sources.** The ISP background check information obtained by the LTC facilities did not disclose all disqualifying convictions. However, our use of the NCIC for background checks disclosed that one employee had a disqualifying conviction in 198 1, or five years prior to being employed. At the time of our audit fieldwork, this conviction was not identified in the ISP records. Since Illinois law requires the LTC facilities to use ISP criminal conviction data for background checks, information related to the status of Illinois arrests or criminal convictions from outside of Illinois is not available. A significant portion of Illinois' population is located along neighboring State lines. The CNAs living in these areas could have out-of-state convictions that would disqualify them from employment. In addition, individuals relocating to Illinois could have disqualifying convictions elsewhere in the country. Therefore, the provisions of the HCWBC Act should be expanded to allow LTC facilities access to a more comprehensive data base of arrests and criminal convictions and to develop the court disposition of arrests.

The task force also addressed the issue of requiring fingerprint-based criminal history records and FBI checks. It recommended that FBI checks be required for a certain category of employee. For example, FBI checks should be required for all individuals who are not Illinois residents or have not been an Illinois resident for a specific period of time, e.g., 24 months, three years. The report went on to state that:

> *" While this procedure would alter the current process, the FBI background check would provide information on serious convictions in other states that would not be known if only an Illinois criminal history were available."*

In addition to the FBI data, other data bases, such as, State police records from contiguous States, could be used.

Although most of the background information that we requested from ISP contained both arrest and conviction information, five of the 88 cases showed arrest data but no final disposition of the cases. Arrest dispositions would be needed to determine if any resulted in a disqualifying conviction. We contacted the county clerks of circuit court offices to obtain final dispositions for these cases. Four of the five cases resulted in convictions of disqualifying offenses. The last case resulted in a non-disqualifying conviction. The ISP data base does not always contain the final disposition of arrest data. State law only requires that conviction information on the ISP data base be disclosed to LTC facilities. Since the Illinois law does not require the disclosure or the development of the disposition of arrest information, the four disqualifying convictions would not have been available on the background checks received by the LTC facilities. These examples re-emphasize the need to expand the provisions of the HCWBC Act.

## Recommendations

We recommend that the Task Force consider expanding the provisions of the HCWBC Act:

(I) require background checks for all LTC staff, not just the direct health care providers,

(ii) include the use of national criminal data bases and neighboring State data bases, and

(iii) authorize the facilities access to arrest data supplemented by final disposition data from the circuit courts.

**IDPH Comments to Recommendation (I):** In their response, IDPH officials stated that an argument could be made for requiring background checks for all staff. On the other hand, they expressed concern about the increased costs involved for the additional staff. The IDPH agreed that this is an issue that deserves further study and will refer it to the Chairman of the Health Care Worker Task Force for its consideration.

**OIG Response:** We believe that the background checks should be expanded to include all LTC staff and that the issue of increased costs should be balanced against the need to ensure the safety of residents.

**IDPH Comments to Recommendation (ii):** The IDPH officials stated that the auditors had identified a serious weakness in the HCWBC Act and that the issue would be referred to the Task Force for further study. They agreed that there should be some method for employers to check for out-of-state convictions. They also stated that while the Health Care Worker Task Force recommended that the Act be amended to require such checks for relatively new residents, it also recognized that there may be problems with cost and availability of the federal checks in rural areas. Some concerns were also raised about the possibility that State law could authorize that FBI checks could be sent directly to the employer and about the accuracy of the FBI checks.

**OIG Response:** The IDPH's proposed action has adequately addressed the recommendation.

**IDPH Comments to Recommendation (iii):** While agreeing that the recommendation would help alert employers, the IDPH officials were concerned that arrest information which did not result in a conviction might be wrongly used by some employers, and the wrongful use would have a disproportional effect on minorities. They stated that this issue will also be referred to the Task Force.

**OIG Response:** We believe that arrest information would provide another useful tool to employers. Regarding wrongful use of this information, prospective employees could be provided protection by prohibiting LTC facilities from not hiring someone based solely on arrest information.

APPENDIX A

# INCIDENT REPORTS NOT PROCESSED AS COMPLAINTS BY IDPH

| Sample # | Allegation Description | Employee Outcome |
|---|---|---|
| 1 | CNA slapped resident on leg | Terminated |
| 2 | CNA put hand over resident's mouth | Terminated |
| 4 | CNA struck resident in the chest | Employee transferred |
| 11 | CNA inappropriately transferred resident to bed | Terminated |
| 30 | CNA slapped resident on forearm | Terminated |
| 35 | CNA slapped resident on face and buttocks | Terminated |
| 55 | CNA pushed resident | Terminated |
| 66 | CNA threw resident onto the bed | Terminated |
| 72 | CNA grabbed resident's wrist and yanked her out of chair | Employee counseled and given extended probation |
| 76 | CNA tapped resident on chest | Employee temporarily suspended and given written warning |
| 79 | CNA bent resident's finger backwards | Terminated |
| 81 | CNA slapped resident | Terminated |
| 86 | CNA kissed and fondled resident | Terminated |

APPENDIX B

# SCHEDULE OF ALLEGED ABUSERS WITH DISQUALIFYING CONVICTIONS PRIOR TO IMPLEMENTATION OF HCWBC ACT

| SAMPLE # | DISQUALIFYING CONVICTION | DATE |
|---|---|---|
| 10* | AGGRAVATED CRIMINAL SEXUAL ABUSE | 01/85 |
| 14 | FELONY THEFT | 01/76 |
| | BATTERY | 09/95 |
| 15 | RETAIL THEFT-MISDEMEANOR | 05/94 |
| | RETAIL THEFT-FELONY | 07/96 |
| 17 | THEFT - MERCHANDISE | 10/76 |
| 19 | ARMED ROBBERY | 05/85 |
| | ARMED ROBBERY | 11/89 |
| | BURGLARY | 03/94 |
| 25 | DOMESTIC BATTERY | 12/94 |
| | AGGRAVATED BATTERY OF SENIOR CITIZEN | 09/96 |
| 27 | THEFT - UNAUTHORIZED CONTROL | 05/92 |
| 28 | UNLAWFUL USE OF WEAPON | 01/90 |
| 40 | RETAIL THEFT | 01/96 |
| 46 | THEFT FROM PERSON | 03/81 |
| 48 | THEFT | 01/96 |
| 55 | THEFT | 07/93 |
| 90a | THEFT | 09/84 |
| 90b | BATTERY | 11/81 |
| | BATTERY | 04/78 |
| | CRIMINAL POSSESSION MARIJUANA | 03/81 |
| | CRIMINAL POSSESSION WEAPON | 01/82 |
| | ATTEMPTED MURDER | 12/81 |
| 102 | THEFT | 04/87 |
| 105 | THEFT | 06/85 |
| 118* | AGGRAVATED CRIMINAL SEXUAL ASSAULT | 03/97 |
| | AGGRAVATED CRIMINAL SEXUAL ASSAULT OF THE HANDICAPPED | 03/97 |
| | AGGRAVATED BATTERY OF SENIOR CITIZEN | 03/97 |

*** Employees other than CNAs**

Illinois Department of
Public
Health

Jim Edgar, Governor • John R. Lumpkin, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001

April 3, 1998

Mr. Ross A. Anderson, Audit Manager
DHHS/OIG/Office of Audit Services
105 West Adams, 23rd Floor
Chicago, Illinois 60603

Dear Mr. Anderson:

Enclosed are the Illinois Department of Public Health's comments to your most recent draft report entitled "Review of Elder Abuse Identification, Investigation and Resolution Procedures for Illinois Long-Term Care Facilities." We appreciate the time and effort devoted by you and your staff toward considering our previous comments and incorporating many of them into this most recent draft.

Please do not hesitate to contact our staff should you have any questions regarding our comments.

Sincerely,

John R. Lumpkin

John R. Lumpkin, M.D.
Director of Public Health

Enclosure

IDPH Should More Fully Develop Incidents Of Alleged Abuse Where The Facilities Have Taken Disciolinary Actions Or Terminated CNA's.

While IDPH does not conduct onsite investigations in response to most incident reports, it is wrong to suggest that IDPH does not make an independent determination as to whether abuse occurred based on those reports. As described by the auditors, IDPH reviews each report to determine whether to initiate an action against the CNA, seek additional information from the facility, conduct an onsite investigation or close the case. IDPH has removed approximately 150 abusive aides from the workforce each year for the six years it has been using this process. While IDPH agrees that facility disciplinary action is one factor to consider in evaluating a case, IDPH has found that such action does not necessarily merit the weight given to it by the auditors. Consequently, IDPH does close some cases without taking action against the CNA even though the facility has taken disciplinary action. Conversely, IDPH initiates actions against CNA's in cases in which there has been no disciplinary action taken by the facility, even when the facility vigorously objects to such action being taken by IDPH.

Given IDPH's limited staff, the volume of complaints which IDPH is required to investigate onsite and the volume of incident reports alleging abuse, IDPH must exercise some judgment as to which onsite investigations of incident reports are likely to result in cases that can be successfully brought against a CNA. IDPH would note that when an incident report is received from a facility, there is less of a concern about facility compliance than when a complaint is received because the facility report tends to indicate that the facility is addressing the problem. In addition, many of these reports involve single incidents with few witnesses, so it is questionable as to how much more information could be gained through an onsite investigation beyond the witnesses' written statements, or descriptions thereof, which are included with the incident reports. There is little basis for assuming that facilities would not be forthcoming in these reports, since the reports cited by the auditors are ones in which the facility reported that they took disciplinary action based on the alleged abuse at their facility.

Notwithstanding the above, IDPH agrees that improvements can be made to its process for handling these reports. One such improvement has already been made in that all reports indicating an employee was terminated for abuse are being referred to the Illinois State Police so they can make an independent judgment whether to investigate for criminal violations. IDPH maintains a close working relationship with the State Police, and currently funds an IDPH nurse to work there on a full-time basis. In addition to this improvement, IDPH is looking into improving its evaluation process for incident reports, including whether other evidence gathering procedures can be used including conducting more onsite investigations.

IDPH Should Update Its Registry To Include All Instances Of Substantiated Abuse Or Abuse Convictions And A Timely Posting of Background Checks Without Disqualifying Conviction&

IDPH agrees with this recommendation; however, IDPH would emphasize that the backlog of background checks without disqualifying convictions had no impact on the safety of patients, residents or clients. This backlog resulted from the huge volume of background checks that came with the implementation of this relatively new law. IDPH has now caught up with the backlog, and the posting of all background checks should proceed in a timely manner.

The INHC Act Should Be Amended So That Those Terminations And Disciplinary Actions Which Resulted From Alleged Abuse And The Documentation Related To These Actions Are Included In The Registry.

IDPH agrees that a past termination or disciplinary action resulting from alleged abuse is one factor fiat a prospective employer should be able to consider in making a hiring decision. IDPH also recognizes that past employers will often not provide this information due to fear of violating certain state and/or federal disclosure laws (e.g., Fair Credit Reporting Act) and possible lawsuits from former employees. However, IDPH does have concerns about adding this information to the nurse aide registry.

Based on its experience and discussions with facility representatives, IDPH does not believe that a facility's decision to terminate an employee based on allegations of abuse is a reliable indicator that abuse occurred. It appears that a number of facilities terminate the alleged abuser regardless of the evidence because it is the facility's belief that termination must occur in order for the facility to protect itself At times, this occurs without the facility having even discussed the allegation with the accused. Moreover, based on its experience and discussions with advocacy groups, IDPH believes that there are some instances in which these terminations are actually in retaliation for such things as union activity, filing a Workmen's Compensation claim, reporting abuse, or cooperating with IDPH in an investigation. IDPH is concerned that placing these terminations on a state-operated registry may cause the allegations to be given a level of credibility which may not exist, and employers may be afraid to hire simply because the state is involved in making a recording.

IDPH agrees that any law requiring that disciplinary actions arising from allegations of abuse be recorded on the registry would have to include some form of due process. IDPH also recognizes that such due process should alleviate concerns over whether there was any basis for the disciplinary action. However, this would in essence require IDPH to pursue all terminations in the same manner that it pursues cases in which it has determined that sufficient evidence exists to take action against the CNA. IDPH believes that a better use of its limited resources is to evaluate each case individually, taking into account facility disciplinary action as just one factor in deciding whether a case merits further action.

The auditors have raised a very significant point regarding the absence of information for prospective employers. However, rather than adding this information to the registry, IDPH believes this can be better addressed by mandating that past employers provide this information to prospective employers. Any such change in the law could include protections for good-faith reporting. IDPH will refer this issue to the Chairman of the Health Care Worker Task Force for further study.

The HCWBC Act Should Be Expanded To Require Background Checks For All Long-Term Care Staff, Not Just The Direct Health Care Providers

The issue of whether the Act should be expanded to non-direct care workers was debated at some length by the Health Care Worker Task Force which was appointed to study the HCWBC Act. Clearly, an argument can be made that the law should cover all workers with direct access to patients,

residents or clients, and not just to direct care workers. On the other hand, questions were raised as to whether expanding the law would be justified, given the substantial increase in costs that would result and the hardship on low income employees who would be put out of work during the waiver process. In considering these issues, it should be noted that the HCWBC Act covers other health care employers in addition to long-term care facilities, including hospitals.

IDPH agrees that this is an issue that deserves further study, and will refer it to the Chairman of the Health Care Worker Task Force for further study.

The HCWBC Act Should Be Expanded To Include The Use Of Criminal Data Bases And Neighboring State Data Bases.

IDPH agrees that there should be some method for employers to check for out-of -state convictions, particularly given the number of employees who come from other states to work in Illinois. However, while the Health Care Worker Task Force did recommend amending the Act to require such checks for relatively new Illinois residents, the Task Force also recognized that there may be problems with cost and availability of the federal checks in rural areas. In addition, it may not be possible to authorize through state law that FBI checks be sent directly to employers and concerns were raised about the accuracy of the FBI checks.

Clearly the auditors have identified a significant weakness in the HCWBC Act. IDPH will refer this issue to the Chairman of the Health Care Worker Task Force for further study as to whether it is financially and technologically feasible to implement the auditors' recommendations.

The HCWBC Act Should Be Exoanded To Authorize The Facilities Access To Arrest Data Supplemented By Final Disposition Data From The Circuit Courts

Under current law, neither IDPH nor facilities are privy to the arrest information that was reviewed by the auditors, While IDPH agrees that following this recommendation would help alert employers to some convictions that have not yet reached the ISP data base, IDPH believes that they may be valid reasons why arrest information is not currently available. Specifically, IDPH believes there are concerns that information on arrests that did not result in convictions might be wrongly used by employers, and that such wrongful use would have a disproportional impact on minorities.

IDPH will refer this issue to the Chairman of the Health Care Worker Task Force for further study.